AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

December 21, 2011

Quick Links

MA-ACA Website

Join Our Mailing List

These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant and Demonstration Announcements

12/20/11 CMS announced the Independence at Home Demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at improving health outcomes and reducing expenditures. The Demonstration, authorized under §3024 of the ACA and supported by the CMS Innovation Center, greatly expands the scope of in-home services Medicare beneficiaries can receive and will provide chronically ill patients with a complete range of primary care services.

Medical practices eligible to participate in the Demonstration must include physicians or nurse practitioners who have experience delivering home-based primary care. As many as 50 practices will be selected and each must serve at least 200 Medicare fee-for-service beneficiaries with multiple chronic conditions and functional limitations. Practices in the demonstration will be responsible for coordinating patient care with other health and social service professionals.

The Demonstration will reward healthcare providers that illustrate a reduction in Medicare expenditures through an incentive payment if they succeed in providing high-quality care while reducing costs. CMS will use quality measures to ensure beneficiaries experience high quality care. Participation in the Demonstration is voluntary for Medicare beneficiaries. CMS predicts as many as 10,000 Medicare patients with chronic conditions will benefit from the demonstration.

Applications and Letters of Intent, if applicable, are due on February 6, 2012.

Additional information about this demonstration, including how to apply, can be found at: http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf

Read the press release from CMS at: Press Release

Visit the Demonstration website at: Demonstration Website

Guidance

12/16/11 HHS released a pre-rule Essential Health Benefits (EHB) Bulletin which outlines proposed policies for states to implement §1302(a) of the ACA requires that health plans offered through the Exchange and through the small/non-group market cover Essential Health Benefits. In the bulletin HHS describes the proposal as comprehensive, affordable and flexible and informs the public about the approach that HHS intends to pursue in future rulemaking to define essential health benefits.

As mandated by the ACA, states must ensure the essential health benefits package covers medical services and treatments in at least ten broad categories of care, including: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management, and Pediatric services, including oral and vision care.

HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the announced approach, states would have the flexibility to select a "benchmark" plan for the items and services included in the essential health benefits package that reflect the scope of services offered by a "typical employer plan." States would choose one of the following health insurance plans as a benchmark: 1) One of the three largest small group plans in the state; 2) One of the three largest state employee health plans; 3) One of the three largest federal employee health plan options; or 4) The largest HMO plan offered in the state's commercial market. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. The policy proposed by HHS would give states the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state. States and insurers would retain the flexibility to evolve the benefits package with the market as future plan designs are developed and advancements in care become available.

The Essential Health Benefits Bulletin was developed after analyzing reports from the Department of Labor and the Institute of Medicine, extensive internal HHS research, and significant input from states, consumer representatives, employers, issuers, providers, and other stakeholders. The bulletin addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments, and coinsurance.

Comments on the proposal are due by January 31, 2012.

Read the essential health benefits bulletin at:
http://cciio.cms.gov/resources/regulations/index.html#hie
Read the press release at: http://www.hhs.gov/news/press/2011pres/12/20111216b.html
Read a fact sheet on the essential health benefits bulletin at:
http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

For a summary of individual market coverage as it relates to essential health benefits, visit: http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml

For information comparing benefits in small group products and state and Federal employee plans, visit: http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.shtml

12/19/11 CMS published a proposed rule regarding Transparency Reports and Reporting of Physician Ownership or Investment Interests in Medicare, Medicaid and the Children's Health Insurance Programs (known as the Sunshine law) as required by §6002 of the ACA. The proposed rule would require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program to report to CMS payments or other transfers of value they make to physicians and teaching hospitals. The proposed rule would also require manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests. Drug and biologic manufacturers, medical device or supply manufacturers, and GPOs, as well as the physicians and teaching hospitals, would be allowed an opportunity to review and correct information prior to its publication.

The ACA provides that violators of the reporting requirements will be subject to civil monetary penalties, capped at $150,000 annually for failing to report, and $1,000,000 for knowingly failing to report.

Although the ACA requires that data collection begin on January 1, 2012, with the first report due on March 31, 2013, the rule proposes that manufacturers and GPOs do not need to begin data collection until final regulations are issued. Depending on the timing of the final rule, CMS is proposing that manufacturers and GPOs will be required to submit data for only part of 2012 by March 31, 2013. Once the data has been submitted, CMS will aggregate manufacturer submissions at the individual physician and teaching hospital level, provide them with a 45-day period to confidentially review and, if necessary, correct the data, and make the data publicly available by September 30, 2013.

Comments are due by February 17, 2012.

Read the proposed rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-19/pdf/2011-32244.pdf
Read the CMS press release at: Press Release

Prior guidance can be viewed at www.healthcare.gov

News

12/19/11 HHS announced the selection of the first thirty-two health care organizations that will participate in a new Pioneer Accountable Care Organizations (ACOs) initiative, authorized by the Medicare Shared Savings Program under §3022 of the ACA and operated by the CMS Innovation Center.

Selected Pioneer ACOs include physician-led organizations and health systems, urban and rural organizations, and organizations in various geographic regions, representing 18 states and the opportunity to improve care for approximately 860,000 Medicare beneficiaries. The Pioneer ACO model is designed specifically for groups of providers that have already begun work coordinating care for patients by providing a path for mature ACOs to move forward.

Under the initiative, Medicare will reward ACO provider groups based on how well they are able to both improve the health of their Medicare patients and lower their health care costs. According to HHS, the initiative could save the Medicare program up to $1.1 billion over five

years. The first performance period of the Pioneer ACO Model will begin January, 1 2012. The initiative is designed to test the effectiveness of various innovative payment models and how they can help experienced organizations to improve care for beneficiaries, work in coordination with private payers, and reduce Medicare cost growth. These payment models will allow organizations that are successful in achieving better care and lower cost growth to move away from a payment system based on volume under the fee-for-service model, towards one where the ACO is paid based on the value of care it provides.

Five Massachusetts organizations were selected: Atrius Health Services, Beth Israel Deaconess Physician Organization, Mount Auburn Cambridge Independent Practice Association (MACIPA), Partners Healthcare and Steward Health Care System. For the complete list of participating Pioneer ACOs and more information about the Pioneer ACO Model, read a fact sheet at: PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL

The Pioneer ACO Model is one of several initiatives underway at CMS designed to support the formation of ACOs. The Medicare Shared Savings Program and the Advance Payment ACO Model, both announced in October 2011, are also ACO options for providers. For more information, visit www.cms.gov/aco.

12/15/11 HHS/The Center for Consumer Information and Insurance Oversight (CCIIO) rejected a request from Florida for a waiver which would have allowed insurers in that state to phase in the ACA's medical loss ratio (MLR) requirements. **12/19/11 HHS rejected a similar request from the state of Michigan**.

The ACA allows the Secretary to adjust the medical loss ratio (MLR) standard for a state if it is determined that meeting the 80% MLR standard may destabilize the individual insurance market. In order to qualify for this adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers. As part of the ACA, if insurers fall short of the standards in 2011, they'll have to issue rebates for that amount in 2012.

Florida had asked for an MLR adjustment allowing insurers to meet lower thresholds of 68% in 2011, 72% in 2012 and 76% in 2013. But CCIIO determined that "ultimately the state of Florida has a very competitive individual market" and there was not a risk that applying the MLR standard would destabilize the market. Although several companies had threatened to exit the market in 2011, none have; instead the companies were modifying their business plans so they could meet the 80% MLR standard. Based on 2010 data, CCIIO estimated that consumers would get rebates totaling more than $100 million. But CCIIO expects that number to be lower because many insurance carriers are pricing their products in a way that lowers premiums to meet the 80% MLR standard and not be subject to such rebates. CCIIO said there was an "unprecedented amount of public comment" on the application and that their decision will provide consumers with the full benefit of the MLR protections this year. CCIIO received letters from 20 consumer groups in the state and a petition from nearly 3,000 Florida residents urging the agency to deny the request.

Michigan had asked HHS to gradually phase in the MLR standard over the next three years, requesting an adjustment of the MLR standard to 65%, 70%, and 75% for reporting years 2011, 2012, and 2013, respectively. But HHS said that most insurers in the state are either able to meet the 80% standard immediately or adjusting business models to reach the 80% standard. As a result, HHS determined that an adjustment to the MLR standard in Michigan, a large, relatively competitive market, was not necessary.

HHS has approved waivers for Georgia, Iowa, Kentucky, Maine, Nevada, and New Hampshire. HHS has denied requests from Indiana, Louisiana, North Dakota, Delaware and Guam (where it

was determined that the two companies that sell individual policies do not have to pay rebates because they are presumed to meet or exceed the 80% threshold and be compliant). The other states that have applied and are awaiting determinations include: Kansas, Texas, Oklahoma, North Carolina and Wisconsin.

For more information on states and the MLR requirements visit the Center for Consumer Information and Insurance Oversight (CCIIO) website at:
http://cciio.cms.gov/programs/marketreforms/mlr/index.html

12/14/11 The National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) released data illustrating that the extension of dependent health insurance coverage up to age 26 has significantly increased the number of young adults with health insurance. As part of the ACA, insurance plan renewals beginning on September 23, 2010, were required to allow young adults can stay on their parents' insurance plans through age 26.

The estimates show that from September 2010 to June 2011, the percentage of adults 19 to 25 with insurance coverage increased from 64% to 73%, which reflects an additional 2.5 million young adults with coverage. Data from the first three months of 2011 showed that one million more young adults had insurance coverage compared to a year ago. The updated data demonstrates that initial gains made from ACA implementation have continued to grow. The data also shows that from January 2010 through June 2011, for young adults aged 19-25, the overall rate of health insurance coverage was 85%, while the rate for the Northeast region (which includes Massachusetts) was 89%.

For more information about the announcement, read the HHS Issue Brief at:
http://aspe.hhs.gov/health/reports/2011/YoungAdultsACA/ib.shtml
For more information about the CDC NHIS data, visit:
http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201109.pdf

12/14/11 HHS announced $218 million in awards to 26 state, regional, national, or hospital system organizations to be Hospital Engagement Networks as a part of the Partnership for Patients initiative, a nationwide public-private collaboration authorized by the ACA to improve the quality, safety, and affordability of health care for all Americans.

The Hospital Engagement Networks' will be funded with $500 million from the CMS Innovation Center, which was established by §3021 of the ACA. As Hospital Engagement Networks, these organizations develop learning collaboratives for hospitals and help identify solutions already working to reduce healthcare acquired conditions and expand improve patient safety initiatives. They will teach and support other hospitals and health care providers in making patient care safer, and implement a system to track and monitor hospital progress in meeting quality improvement goals. Hospital Engagement Networks' activities will be monitored by CMS to ensure that they are improving patient safety.

In addition to the Hospital Engagement Contract awards, HHS awarded three other contracts to assist in achieving the Partnership for Patients' goals: the National Content Developer Contractor, the Beneficiary and Medical Professional Engagement Contractor, and the Evaluation Contractor. For more information, including the complete list of organizations receiving awards, visit: http://www.hhs.gov/news/press/2011pres/12/20111214d.html

Launched in April 2011, the **Partnership for Patients** consists of more than 6,500 partners, including hospitals, physicians, nurses, patient advocates, consumers and consumer groups, and employers and unions. In addition, health plans, Area Agencies on Aging, and state and federal government officials have pledged to work together to reduce the number of hospital-

acquired conditions by 40% and reduce hospital readmissions by 20% by the end of 2013. HHS has committed up to $1 billion in ACA funding to help achieve the Partnership for Patients goals. In addition to the funding to help reduce health care acquired conditions, $500 million has been made available through the Community-Based Care Transitions Program to ensure patients safely transition between settings of care to reduce readmissions. In November, seven organizations were selected as the first participants for the Community-Based Care Transitions Program. For more information on the Partnership for Patients, please visit http://www.healthcare.gov/partnershipforpatients.

12/13/11 HHS Secretary Kathleen Sebelius announced that Richard Sorian, the department's assistant secretary for public affairs, is leaving his position effective December 15, 2011. Dori Salcido, one of Sorian's deputies, will become Principal Deputy Assistant Secretary for Public Affairs and will serve as the Acting Assistant Secretary.

Sorian was nominated in October 2009. The Senate Finance Committee held a confirmation hearing on his nomination in May 2010 and unanimously approved it in July of that year. However, like former CMS Administrator Donald Berwick, Sorian's confirmation got held up in Congress and was never sent to the Senate floor for a vote. Also like Berwick, President Obama put Sorian in office through a recess appointment, which expires December 31, 2011. Sorian was a former journalist, served in the Clinton White House as an adviser on AIDS policy and also was a media adviser to then-HHS Secretary Donna Shalala. He went on to serve as a senior executive at the National Committee for Quality Assurance. In the Obama administration he led public communications efforts around significant ACA provisions such as the Partnership for Patients initiative.

Salcido has been with HHS' communications team since 2009, first as communications director for the Office of the Assistant Secretary for Health, working closely with Dr. Howard Koh and Surgeon General Regina Benjamin on anti-tobacco and obesity campaigns. Since January 2011 Salcido has served as deputy assistant secretary for public affairs at HHS. She currently manages the news division and oversees communications for several HHS agencies including the FDA, CDC, NIH and Public Health Service. During the Bill Clinton administration, Salcido served as a director of media operations at the White House. She served in the private sector as senior communications director for working for Time Warner's AOL division. She has a B.A. in political science and speech communications from the University of New Mexico, Albuquerque.

HHS has not announced Sorian's official next steps, although he will remain with HHS through January, advising Sebelius on non-media issues to ensure a smooth transition.

EOHHS News

12/21/11 EOHHS held a Quarterly Affordable Care Act Implementation Stakeholder Meeting and the agenda included presentations on recent ACA implementation activities as well as a question and answer session. A presentation was given by the Subsidized Insurance Workgroup, which is tasked with analyzing the subsidized insurance options under the ACA and recommending the state's approach for delivering subsidized insurance. Stakeholders also heard a presentation from the Health Connector on Exchange planning, including information on upcoming Exchange Establishment Grant proposals, which will allow the state to continue its work in planning for and implementing the state health insurance exchange.
View the Subsidized Insurance Workgroup Update Presentation at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/111221-q-subsidized-ins-workgroup-update.ppt

View the Exchange Planning: Establishment Grant Update Presentation

at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/111221-q-exchange-planning-establishment-grant.ppt

All presentations from past Quarterly Stakeholder Meetings are available at http://mass.gov/nationalhealthreform under Materials from Previous Quarterly Stakeholder Meetings.

Upcoming Events

Public Hearing on MassHealth's draft Demonstration Proposal on Integrating Medicare and Medicare for Dual Eligible Individuals
January 4, 2012 from 10 AM -1 PM
(**Please note - this is a change from the previously announced time.**)
State Transportation Building, Conference Rooms 2&3
10 Park Place
Boston, MA

The draft Demonstration Proposal is posted at www.mass.gov/masshealth/duals under "Related Information" and on Comm-PASS (www.comm-pass.com).

Money Follows the Person (MFP) Working Group
Thursday, February 2, 2012 from 2 PM - 3:30 PM
Saxe Conference Room
Worcester Public Library
3 Salem Square
Worcester, MA

Please contact MFP@state.ma.us to attend the MFP meetings and to request reasonable accommodations.

More information on MFP can be found at: Money Follows the Person

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.